

the responsibility to renew that coverage.

(3) Coverage offered within a service area after the 180-day period specified in paragraph (c)(2) of this section is subject to the requirements of this section.

(d) *Application of financial capacity limits.* (1) A health insurance issuer may deny health insurance coverage in the small group market if the issuer has demonstrated to the applicable State authority (if required by the State authority) that it—

(i) Does not have the financial reserves necessary to underwrite additional coverage; and

(ii) Is applying this paragraph (d)(1) uniformly to all employers in the small group market in the State consistent with applicable State law and without regard to the claims experience of those employers and their employees (and their dependents) or any health status-related factor relating to those employees and dependents.

(2) An issuer that denies group health insurance coverage to any small employer in a State under paragraph (d)(1) of this section may not offer coverage in connection with group health plans in the small group market in the State before the later of the following dates:

(i) The 181st day after the date the issuer denies coverage.

(ii) The date the issuer demonstrates to the applicable State authority, if required under applicable State law, that the issuer has sufficient financial reserves to underwrite additional coverage.

(3) Paragraph (d)(2) of this section does not limit the issuer's ability to renew coverage already in force or relieve the issuer of the responsibility to renew that coverage.

(4) Coverage offered after the 180-day period specified in paragraph (d)(2) of this section is subject to the requirements of this section.

(5) An applicable State authority may provide for the application of this paragraph (d) on a service-area-specific basis.

(e) *Exception to requirement for failure to meet certain minimum participation or contribution rules.* (1) Paragraph (a) of this section does not preclude a health insurance issuer from establishing em-

ployer contribution rules or group participation rules for the offering of health insurance coverage in connection with a group health plan in the small group market, as allowed under applicable State law.

(2) For purposes of paragraph (e)(1) of this section—

(i) The term “employer contribution rule” means a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of participants and beneficiaries; and

(ii) The term “group participation rule” means a requirement relating to the minimum number of participants or beneficiaries that must be enrolled in relation to a specified percentage or number of eligible individuals or employees of an employer.

(f) *Exception for coverage offered only to bona fide association members.* Paragraph (a) of this section does not apply to health insurance coverage offered by a health insurance issuer if that coverage is made available in the small group market only through one or more bona fide associations (as defined in 45 CFR 144.103).

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**§ 146.152 Guaranteed renewability of coverage for employers in the group market.**

(a) *General rule.* Subject to paragraphs (b) through (d) of this section, a health insurance issuer offering health insurance coverage in the small or large group market is required to renew or continue in force the coverage at the option of the plan sponsor.

(b) *Exceptions.* An issuer may nonrenew or discontinue group health insurance coverage offered in the small or large group market based only on one or more of the following:

(1) *Nonpayment of premiums.* The plan sponsor has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage, including any timeliness requirements.

(2) *Fraud.* The plan sponsor has performed an act or practice that constitutes fraud or made an intentional

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misrepresentation of material fact in connection with the coverage.

(3) *Violation of participation or contribution rules.* The plan sponsor has failed to comply with a material plan provision relating to any employer contribution or group participation rules permitted under §146.150(e) in the case of the small group market or under applicable State law in the case of the large group market.

(4) *Termination of product.* The issuer is ceasing to offer coverage in the market in accordance with paragraph (c) or (d) of this section and applicable State law.

(5) *Enrollees' movement outside service area.* For network plans, there is no longer any enrollee under the group health plan who lives, resides, or works in the service area of the issuer (or in the area for which the issuer is authorized to do business); and in the case of the small group market, the issuer applies the same criteria it would apply in denying enrollment in the plan under §146.150(c); provided the issuer provides notice in accordance with the requirements of paragraph (c)(1) of this section.

(6) *Association membership ceases.* For coverage made available in the small or large group market only through one or more bona fide associations, if the employer's membership in the association ceases, but only if the coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual.

(c) *Discontinuing a particular product.* In any case in which an issuer decides to discontinue offering a particular product offered in the small or large group market, that product may be discontinued by the issuer in accordance with applicable State law in the particular market only if—

(1) The issuer provides notice in writing, in a form and manner specified by the Secretary, to each plan sponsor provided that particular product in that market (and to all participants and beneficiaries covered under such coverage) of the discontinuation at least 90 days before the date the coverage will be discontinued;

(2) The issuer offers to each plan sponsor provided that particular product the option, on a guaranteed issue

basis, to purchase all (or, in the case of the large group market, any) other health insurance coverage currently being offered by the issuer to a group health plan in that market; and

(3) In exercising the option to discontinue that product and in offering the option of coverage under paragraph (c)(2) of this section, the issuer acts uniformly without regard to the claims experience of those sponsors or any health status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage.

(d) *Discontinuing all coverage.* An issuer may elect to discontinue offering all health insurance coverage in the small or large group market or both markets in a State in accordance with applicable State law only if—

(1) The issuer provides notice in writing to the applicable State authority and to each plan sponsor (and all participants and beneficiaries covered under the coverage) of the discontinuation at least 180 days prior to the date the coverage will be discontinued; and

(2) All health insurance policies issued or delivered for issuance in the State in the market (or markets) are discontinued and not renewed.

(3) For purposes of this paragraph (d), subject to applicable State law, an issuer will not be considered to have discontinued offering all health insurance coverage in a market in a State if—

(i) The issuer (in this paragraph referred to as the initial issuer) or, if the issuer is a member of a controlled group, any other issuer that is a member of such controlled group, offers and makes available in the applicable market in the State at least one product that is considered in accordance with §144.103 of this subchapter to be the same product as a product the initial issuer had been offering in such market in such State; or

(ii) The issuer—

(A) Offers and makes available at least one product (in paragraphs (d)(3)(ii)(A) through (C) of this section referred to as the new product) in the applicable market in the State, even if

such product is not considered in accordance with §144.103 of this subchapter to be the same product as a product the issuer had been offering in the applicable market in the State (in paragraphs (d)(3)(ii)(A) through (C) of this section referred to as the discontinued product);

(B) Subjects such new product or products to the applicable process and requirements established under part 154 of this title as if such process and requirements applied with respect to that product or products, to the extent such process and requirements are otherwise applicable to coverage of the same type and in the same market; and

(C) Reasonably identifies the discontinued product or products that correspond to the new product or products for purposes of the process and requirements applied pursuant to paragraph (d)(3)(ii)(B) of this section.

(4) For purposes of this section, the term controlled group means a group of two or more persons that is treated as a single employer under sections 52(a), 52(b), 414(m), or 414(o) of the Internal Revenue Code of 1986, as amended, or a narrower group as may be provided by applicable State law.

(e) *Prohibition on market reentry.* An issuer who elects to discontinue offering all health insurance coverage in a market (or markets) in a State as described in paragraph (d) of this section may not issue coverage in the market (or markets) and State involved during the 5-year period beginning on the date of discontinuation of the last coverage not renewed.

(f) *Exception for uniform modification of coverage.* (1) Only at the time of coverage renewal may issuers modify the health insurance coverage for a product offered to a group health plan in the following—

(i) Large group market; and

(ii) Small group market if, for coverage available in this market (other than only through one or more bona fide associations), the modification is consistent with State law and is effective uniformly among group health plans with that product.

(2) For purposes of paragraph (f)(1)(ii) of this section, modifications made uniformly and solely pursuant to applicable Federal or State requirements

are considered a uniform modification of coverage if:

(i) The modification is made within a reasonable time period after the imposition or modification of the Federal or State requirement; and

(ii) The modification is directly related to the imposition or modification of the Federal or State requirement.

(3) For purposes of paragraph (f)(1)(ii) of this section, other types of modifications made uniformly are considered a uniform modification of coverage if the health insurance coverage for the product in the small group market meets all of the following criteria:

(i) The product is offered by the same health insurance issuer (within the meaning of section 2791(b)(2) of the PHS Act), or if the issuer is a member of a controlled group (as described in paragraph (d)(4) of this section), any other health insurance issuer that is a member of such controlled group;

(ii) The product is offered as the same product network type (for example, health maintenance organization, preferred provider organization, exclusive provider organization, point of service, or indemnity);

(iii) The product continues to cover at least a majority of the same service area;

(iv) Within the product, each plan has the same cost-sharing structure as before the modification, except for any variation in cost sharing solely related to changes in cost and utilization of medical care, or to maintain the same metal tier level described in sections 1302(d) and (e) of the Affordable Care Act; and

(v) The product provides the same covered benefits, except for any changes in benefits that cumulatively impact the rate for any plan within the product within an allowable variation of  $\pm 2$  percentage points (not including changes pursuant to applicable Federal or State requirements).

(4) A State may only broaden the standards in paragraphs (f)(3)(iii) and (iv) of this section.

(g) *Application to coverage offered only through associations.* In the case of health insurance coverage that is made available by a health insurance issuer in the small or large group market to employers only through one or more

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associations, the reference to “plan sponsor” is deemed, with respect to coverage provided to an employer member of the association, to include a reference to such employer.

(h) *Notice of renewal of coverage.* If an issuer in the small group market is renewing grandfathered coverage as described in paragraph (a) of this section, or uniformly modifying grandfathered coverage as described in paragraph (f) of this section, the issuer must provide to each plan sponsor written notice of the renewal at least 60 calendar days before the date the coverage will be renewed in a form and manner specified by the Secretary.

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### § 146.160 Disclosure of information.

(a) *General rule.* In connection with the offering of any health insurance coverage to a small employer, a health insurance issuer is required to—

(1) Make a reasonable disclosure to the employer, as part of its solicitation and sales materials, of the availability of information described in paragraph (b) of this section; and

(2) Upon request of the employer, provide that information to the employer.

(b) *Information described.* Subject to paragraph (d) of this section, information that must be provided under paragraph (a)(2) of this section is information concerning the following:

(1) Provisions of coverage relating to the following:

(i) The issuer’s right to change premium rates and the factors that may affect changes in premium rates.

(ii) Renewability of coverage.

(iii) Any preexisting condition exclusion, including use of the alternative method of counting creditable coverage.

(iv) Any affiliation periods applied by HMOs.

(v) The geographic areas served by HMOs.

(2) The benefits and premiums available under all health insurance coverage for which the employer is quali-

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fied, under applicable State law. See § 146.150(b) through (f) for allowable limitations on product availability.

(c) *Form of information.* The information must be described in language that is understandable by the average small employer, with a level of detail that is sufficient to reasonably inform small employers of their rights and obligations under the health insurance coverage. This requirement is satisfied if the issuer provides each of the following with respect to each product offered:

(1) An outline of coverage. For purposes of this section, outline of coverage means a description of benefits in summary form.

(2) The rate or rating schedule that applies to the product (with and without the preexisting condition exclusion or affiliation period).

(3) The minimum employer contribution and group participation rules that apply to any particular type of coverage.

(4) In the case of a network plan, a map or listing of counties served.

(5) Any other information required by the State.

(d) *Exception.* An issuer is not required to disclose any information that is proprietary and trade secret information under applicable law.

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[62 FR 16958, Apr. 8, 1997, as amended at 62 FR 35906, July 2, 1997]

## Subpart F—Exclusion of Plans and Enforcement

### § 146.180 Treatment of non-Federal governmental plans.

(a) *Opt-out election for self-funded non-Federal governmental plans—*(1) *Requirements subject to exemption.* The PHS Act requirements described in this paragraph are the following:

(i) Limitations on preexisting condition exclusion periods in accordance with section 2701 of the PHS Act as codified before enactment of the Affordable Care Act.

(ii) Special enrollment periods for individuals and dependents described under section 2704(f) of the PHS Act.